

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24153

STATE FILE NUMBER

FILED AUG 12 1957

Registration District No. 128 Primary Registration District No. 200 Registrar's No. 794

1. PLACE OF DEATH a. COUNTY Greene				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Arkansas b. COUNTY Miller			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Springfield				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN Texarkana 8030	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 1613 Waverly				Length of stay in 1b 2 wks.		d. STREET ADDRESS (If outside, give location) 2312 Garland Ave.	
3. NAME OF DECEASED (Type or print) First Augustus Middle Albert Last Duflot				4. DATE OF DEATH Month Aug. Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 2, 1878	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Moulder		10b. KIND OF BUSINESS OR INDUSTRY Foundry		11. BIRTHPLACE (City and state or country) Kentucky		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Duflot				14. MOTHER'S MAIDEN NAME Marie A. Fleith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 431-09-6380A		17. INFORMANT (Son) Address Basil A. Duflot-Springfield, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) Carcinoma, hepatic DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1561							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 2							
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1561			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		COUNTY _____ STATE _____	
21. I attended the deceased from 7:23, 57 to 8, 8, 57 and last saw her alive on 8, 8, 57 Death occurred at 7:00 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) James W. Smith				22b. ADDRESS 505 Medical Arts Bldg. Springfield, Mo.		22c. DATE SIGNED 8, 8, 57	
23a. BURIAL LOCATION Removal		23b. DATE 8-8-1957		23c. NAME OF CEMETERY OR CREMATORY Stateline Cemetery		23d. LOCATION (City, town, or county) (State) Texarkana, Arkansas	
24. FUNERAL DIRECTOR James W. Smith				25. DATE RECD. BY LOCAL REG. 8-8-57		26. REGISTRAR'S SIGNATURE James W. Smith	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes.

AUG 21 1957

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____
Licensed Embalmer No. 331

P. O. Address Springfield

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING.
to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.